

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5553 CERTIFICATE OF DEATH

Reg. Dist. No.

05546

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN TB entire life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Robinson Andrews		4. DATE OF DEATH May 26, 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1901	
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) Cambridge, Md.		13. CITIZEN OF WHAT COUNTRY? U.S.	
14. FATHER'S NAME J. Edgar Robinson		15. MOTHER'S MAIDEN NAME Mollie Males	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 219-14-2990	
18. INFORMANT Walter B. Andrews		Address 303 Somerset Ave., Cambridge, Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 146x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Epithelial Sarcoma of posterior nasopharynx DUE TO (c) Generalized sarcomatosis		INTERVAL BETWEEN ONSET AND DEATH 5-6 days 15 months 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- 19 p. m. --		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-58 , 19 58 to 5-26-59 , 19 59 , that I last saw the deceased alive on 5-26-59 , 19 59 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldridge H. Wolff		ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md.	
DATE SIGNED 5-27-59			
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

10-22-23

10-22-23

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1878		Maryland		Baltimore		Heart Disease		Oct 20, 1923		10:00 AM		Home		J. H. Smith		W. B. Jones	
Occupation		Married		Single		Widowed		Divorced		Color		Race		Religion		Education		Previous Illness		Previous Injuries		Previous Operations	
Teacher		Yes		No		No		No		White		Caucasian		Roman Catholic		High School		None		None		None	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Oct 20, 1923		10:00 AM		Home		J. H. Smith		W. B. Jones		Oct 20, 1923		10:00 AM		Home		J. H. Smith		W. B. Jones		Oct 20, 1923		10:00 AM	

10-22-23

5564 CERTIFICATE OF DEATH

05547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1yr 8mo 13days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cooper Middle - Last Bickling		4. DATE OF DEATH Month May Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel C. Bickling		14. MOTHER'S MAIDEN NAME Sarah Ayres	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown --		16. SOCIAL SECURITY NO. 221-10-0914	
17. INFORMANT RECORDS: Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 31, 1954 to May 13, 1959 , that I last saw the deceased alive on May 13, 1959 , and that death occurred at 6:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George E. Currier		ADDRESS (Street, city or town, state) Eastern Shore State Hospital DATE SIGNED 5-13-59	
PHYSICIAN'S NAME (Type) George E. Currier, M.D.		Eastern Shore State Hospital, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-16-59	22c. NAME OF CEMETERY OR CREMATOR Templeville	22d. LOCATION (City, town, or county) (State) Templeville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John E. Boulais		24a. REC'D BY REGISTRAR May 15 '59	
ADDRESS Greenboro, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

U.S. GOVERNMENT PRINTING OFFICE: 1967 O 345-230

Figure 1

1570

5554 CERTIFICATE OF DEATH

05548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>13</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>CAMBRIDGE 13</u>	
3. NAME OF DECEASED (Type or print) First <u>NARCISSE</u> Middle <u>Chester</u> Last <u></u>		4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-15 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STANLEY E. W. CAMPER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE CLASH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Stewart Camper</u> Address <u>Cambridge</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>52</u> , to <u>11 May</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11 May</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St Cambridge Md.</u> DATE SIGNED <u>5-14-59</u> ACTUAL SIGNATURE <u>J. Edwin Fasset</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Edwin Fasset</u> <u>Cambridge Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-14-59</u>		22b. DATE THEREOF <u>Bethel</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon H. Henry</u> ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

82528

3704 CEMENTATE OF CEMENT

1

1

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05549

5565

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Dor</u>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	
		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Norma</u> Middle <u>Merrick</u> Last <u>Clifton</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/1895</u>
9. AGE (In years last birthday) <u>64</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Swilley Merrick</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Maybray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>111-11-1111</u>	
17. INFORMANT <u>Hubert Clifton</u>		Address <u>East New Market, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>1 hour</u> <u>1 month</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/11/59</u> , 19 <u>59</u> , to <u>5/7/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/24/59</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.		ADDRESS (Street, city or town, state) <u>136 Race St.</u> DATE SIGNED <u>5/7/59</u>	
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>		<u>Cambridge, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/9/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Shillock, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kline</u>		ADDRESS <u>East New Market</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAY 11 '59</u>		<u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5566

CERTIFICATE OF DEATH

Reg. Dist. No. 05550

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 2yr.8mo.23das	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 2212-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 237 Lincoln Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Laura Middle Cassins Last Conner		4. DATE OF DEATH Month May Day 14 Year 1959	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-90
9. AGE (In years last birthday) 68 yrs.		10. AGE (In years last birthday) 68 yrs.	11. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ? John Willis	
14. MOTHER'S MAIDEN NAME Mary Elizabeth Argo		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. ?		INFORMANT RECORDS - Eastern Shore State Hospital	
17. ADDRESS ?		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis	
19. INTERVAL BETWEEN ONSET AND DEATH Sev. yrs.		20. INTERVAL BETWEEN ONSET AND DEATH Sev. yrs.	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that I attended the deceased from August 22 , 19 56 , to May 14 , 19 59 , that I last saw the deceased alive on May 14 , 19 59 , and that death occurred at 2:30A M, from the causes and on the date stated above.		30. ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED 5-14-59	
31. ACTUAL SIGNATURE Dr. Simon Virkutis		32. PHYSICIAN'S NAME (Type) Dr. Simon Virkutis	
33a. BURIAL, CREMATION, REMOVAL (Specify) Burial		33b. DATE THEREOF 5-17-59	
33c. NAME OF CEMETERY OR CREMATORY Odd Fellows		33d. LOCATION (City, town, or county) (State) Camden Del.	
34. FUNERAL DIRECTOR'S SIGNATURE William E. Sham		35. ADDRESS Georgetown St.	
36. REC'D BY REGISTRAR DATE MAY 18 '59		37. REGISTRAR'S SIGNATURE Arthur L. Kins	

10-550

CERTIFICATE OF DEATH

10-550

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF WITNESSES

NAME OF REGISTRAR

NAME OF OFFICIAL

NAME OF OFFICIAL

NAME OF OFFICIAL

NAME OF OFFICIAL

NAME OF OFFICIAL

NAME OF OFFICIAL

5567

CERTIFICATE OF DEATH

05551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eldorado		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maude Middle Foxwell Last Curtiss		4. DATE OF DEATH Month May Day 29 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1892
9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis J. Foxwell		14. MOTHER'S MAIDEN NAME Rebecca A. Rhodes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Miss Theresa E. Murphy, Rhodesdale, Md., RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction due to carcinoma 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of ovary with metastases to pelvis, DUE TO (c) peritoneum and right pleural space.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1959 , to May 29 , 19 59 , that I last saw the deceased alive on May 29 , 19 59 , and that death occurred at 9 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Lennon M.D.		DATE SIGNED June 1, 1959	
PHYSICIAN'S NAME (Type) W. E. Lennon		ADDRESS (Street, city or town, state) Federalsburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 1, 1959	22c. NAME OF CEMETERY OR CREMATORY Eldorado Cemetery	22d. LOCATION (City, town, or county) (State) Eldorado, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE JUN 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

05551

CERTIFICATE OF DEATH

1. Name of deceased: *William J. Brown*

2. Date of death: *March 7, 1955*

3. Place of death: *Home, 123 Main St., New York, N.Y.*

4. Cause of death: *Myocardial infarction (heart attack)*

5. Physician: *Dr. J. H. Smith*

6. Burial place: *St. John's Cemetery, New York, N.Y.*

7. Age at death: *68 years*

8. Sex: *Male*

9. Race: *White*

10. Marital status: *Married*

11. Occupation: *Engineer*

12. Signature of physician: *J. H. Smith*

13. Signature of registrar: *M. E. Johnson*

14. Date of registration: *March 10, 1955*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5568

Item 1c Film G243 5-25-59 et

CERTIFICATE OF DEATH

05552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lewis First Thomas Daugherty Middle Thomas Last Daugherty		4. DATE OF DEATH May 19 1959 Month May Day 19 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 21 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishing	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Daugherty		14. MOTHER'S MARDEN NAME Emma Tyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Eastern Shore State Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate 177X DUE TO (b) 177X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) 177X			INTERVAL BETWEEN ONSET AND DEATH UNK
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1959 , to May 19, 1959 , that I lost sow the deceased olive on May 18, 1959 , and that death occurred at 5:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Dredge		DATE SIGNED E.S.S. Hospital, Cambridge, Md. 5-19-59	
PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/59	
22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Memorial		22d. LOCATION (City, town or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons		24a. REC'D BY REGISTRAR May 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

DEATH CERTIFICATE

1900

1

1

1900

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1900

1900

1900

1900

1900

1900

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5555 CERTIFICATE OF DEATH

05553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland</u>		d. STREET ADDRESS <u>Secretary</u>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Dean</u> Middle <u>Dean</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - Ret.</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James M. Deane</u>	
14. MOTHER'S MAIDEN NAME <u>Rebecca Deane</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. Harry Dean, Secretary, MD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.2</u> DUE TO <u>mesenteric thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> ?		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>5-13</u> , 19 <u>59</u> , to <u>5-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-13-59</u> , 19 <u>59</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>M. Bannan</u> M.D.		ADDRESS (Street, city or town, state) <u>Cambridge</u> DATE SIGNED <u>5-15-59</u>	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>5/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	
22d. LOCATION (City, town, or county) (State) <u>East New Market MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Willoughby</u> ADDRESS <u>East New Market</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. RACE		7. RELIGION		8. MARRIAGE		9. OCCUPATION		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF NOTARY		20. SIGNATURE OF OTHER	
								</																															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5569 CERTIFICATE OF DEATH

05554

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 6yr.3mo.30das	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS -	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Dixon		4. DATE OF DEATH Month May Day 20 Year 19 59	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-74
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Timms		14. MOTHER'S MAIDEN NAME Mary Elizabeth Conroy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Address RECORDS - Eastern Shore State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1 , 19 57 , to May 20 , 19 59 , that I last saw the deceased alive on May 20 , 19 59 , and that death occurred at 9:12PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED E. DeFilippis M.D. E.S.S. Hospital, Cambridge, Md. 5-21-59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. E. DeFilippis			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

10554

STATE OF TEXAS

1955

County of _____

State of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

County of _____

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5570 Item 9 FilmG242 5-18-59 et

CERTIFICATE OF DEATH

05556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Dorchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>2 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of name) <i>STOBES HURLEY</i> First Middle Last		4. DATE OF DEATH <i>5-10-59</i> Month Day Year	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-1-71</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	9. AGE (In years lost birthday) <i>88 1/2</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Md., U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ezra R. Hurley</i>		14. MOTHER'S MAIDEN NAME <i>Sallie Horseman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Hospital records, E.S.S.H.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Cardiovascular Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>General Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-29</i> , 19 <i>57</i> to <i>5-10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5-10-</i> , 19 <i>59</i> , and that death occurred at <i>6:30 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ettore DeFilippis</i> M.D.		ADDRESS (Street, city or town, state) <i>Eastern Shore State Hosp.</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>ETTORE DEFILIPPIS</i>		<i>Cambridge, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 12, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Dorchester Memorial Park</i>	22d. LOCATION (City, town, or county) (State) <i>Cambridge, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Reuben R. Thomas</i> ADDRESS <i>Cambridge, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE MAY 13 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>

MEDICAL CERTIFICATION

CERTIFICATE OF BIRTH

43558

1

JOHN H. KELLY

Male

White

Single

Occupation

Address

City

State

County

Birth Date

Birth Place

Parents

Signature

Witness

Registrar

Official Seal

Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the funeral director for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5556 CERTIFICATE OF DEATH

05557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 11 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE MARYLAND HOSP.			d. STREET ADDRESS 223 HENRY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CELIA ROSE JACKSON			4. DATE OF DEATH Month MAY Day 28 Year 19 59		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 11 1883		9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMTRESS		10b. KIND OF BUSINESS OR INDUSTRY GARMENT FACTORY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JAMES ROSE			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME ELIZABERTH TUCKER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKN OWN		17. INFORMANT MES NELSON THOMAS CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomucinous cystadenocarcinoma of right ovary with wide spread abdominal metastases DUE TO (b) Spread abdominal metastases DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Mar 17, 1959 , to May 28, 1959 , that I last saw the deceased alive on May 28, 1959 , and that death occurred at 9 A. M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Lewis M. Burdette			DATE SIGNED 5/29/59		
PHYSICIAN'S NAME (Type) Lewis M. Burdette			ADDRESS (Street, city or town, state) 1 Locust St Cambridge, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 31, 1959		22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEN PARK	
22d. LOCATION (City, town, or county) CAMBRIDGE MARYLAND					
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FUNERLA SERVICE			24a. REC'D BY REGISTRAR JUN 1 '59		
ADDRESS CAMBRIDGE MARYLAND			24b. REGISTRAR'S SIGNATURE Arthur L. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5557 CERTIFICATE OF DEATH

Reg. Dist. No.

05558

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		d. STREET ADDRESS <u>1 228 High Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Coleman</u> Last <u>Kiah</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1883</u>
9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Esaw Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Sampson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Helen C. Waters, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/30</u> , 19 <u>59</u> to <u>5/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/3</u> , 19 <u>59</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Locust St Cambridge Md</u> DATE SIGNED <u>5/5/59</u> ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D. PHYSICIAN'S NAME (Type) <u>W. H. Hanks M.D</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/6/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Bell</u>		24a. REC'D BY REGISTRAR <u>May 26 '59</u>	
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1920</i>		6. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
7. DATE OF DEATH <i>Feb 10 1965</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Myocardial Infarction</i>	
11. DISEASE OR INJURY <i>Coronary Artery Disease</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF NEAREST RELATIVE <i>John Doe, Jr.</i>	
17. SIGNATURE OF CLERK <i>John Doe</i>		18. SIGNATURE OF REGISTRAR <i>John Doe</i>	
19. SIGNATURE OF JUDGE <i>John Doe</i>		20. SIGNATURE OF SHERIFF <i>John Doe</i>	
21. SIGNATURE OF DISTRICT ATTORNEY <i>John Doe</i>		22. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
23. SIGNATURE OF CITY CLERK <i>John Doe</i>		24. SIGNATURE OF VICE MAYOR <i>John Doe</i>	
25. SIGNATURE OF MAYOR <i>John Doe</i>		26. SIGNATURE OF COMMISSIONER <i>John Doe</i>	
27. SIGNATURE OF SECRETARY <i>John Doe</i>		28. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>	
29. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>		30. SIGNATURE OF DEPUTY CHIEF OF BUREAU <i>John Doe</i>	
31. SIGNATURE OF ASSISTANT DEPUTY CHIEF OF BUREAU <i>John Doe</i>		32. SIGNATURE OF CLERK <i>John Doe</i>	
33. SIGNATURE OF RECEPTIONIST <i>John Doe</i>		34. SIGNATURE OF MAIL ROOM <i>John Doe</i>	
35. SIGNATURE OF TELEPHONE ROOM <i>John Doe</i>		36. SIGNATURE OF RECORDS ROOM <i>John Doe</i>	
37. SIGNATURE OF GENERAL INVESTIGATIVE DIVISION <i>John Doe</i>		38. SIGNATURE OF IDENTIFICATION DIVISION <i>John Doe</i>	
39. SIGNATURE OF LABORATORY DIVISION <i>John Doe</i>		40. SIGNATURE OF RADIOLOGICAL DIVISION <i>John Doe</i>	
41. SIGNATURE OF PATHOLOGICAL ANATOMY DIVISION <i>John Doe</i>		42. SIGNATURE OF FORENSIC MEDICINE DIVISION <i>John Doe</i>	
43. SIGNATURE OF CRIMINOLOGY DIVISION <i>John Doe</i>		44. SIGNATURE OF SOCIAL WORK DIVISION <i>John Doe</i>	
45. SIGNATURE OF PUBLIC HEALTH DIVISION <i>John Doe</i>		46. SIGNATURE OF NURSING DIVISION <i>John Doe</i>	
47. SIGNATURE OF DENTAL DIVISION <i>John Doe</i>		48. SIGNATURE OF OPTICIAN DIVISION <i>John Doe</i>	
49. SIGNATURE OF PHARMACY DIVISION <i>John Doe</i>		50. SIGNATURE OF FOOD AND DRUG DIVISION <i>John Doe</i>	
51. SIGNATURE OF ALCOHOL, TOBACCO AND NARCOTICS DIVISION <i>John Doe</i>		52. SIGNATURE OF GAMING DIVISION <i>John Doe</i>	
53. SIGNATURE OF LOTTERY DIVISION <i>John Doe</i>		54. SIGNATURE OF RACING DIVISION <i>John Doe</i>	
55. SIGNATURE OF AMUSEMENT DIVISION <i>John Doe</i>		56. SIGNATURE OF PARKS AND RECREATION DIVISION <i>John Doe</i>	
57. SIGNATURE OF HISTORIC LANDMARKS DIVISION <i>John Doe</i>		58. SIGNATURE OF MONUMENTS AND MARKERS DIVISION <i>John Doe</i>	
59. SIGNATURE OF ARCHIVES DIVISION <i>John Doe</i>		60. SIGNATURE OF LIBRARY DIVISION <i>John Doe</i>	
61. SIGNATURE OF MUSEUM DIVISION <i>John Doe</i>		62. SIGNATURE OF BOTANICAL GARDEN DIVISION <i>John Doe</i>	
63. SIGNATURE OF ZOOLOGICAL GARDEN DIVISION <i>John Doe</i>		64. SIGNATURE OF AQUARIUM DIVISION <i>John Doe</i>	
65. SIGNATURE OF CONSERVATION DIVISION <i>John Doe</i>		66. SIGNATURE OF PARKS AND RECREATION DIVISION <i>John Doe</i>	
67. SIGNATURE OF HISTORIC LANDMARKS DIVISION <i>John Doe</i>		68. SIGNATURE OF MONUMENTS AND MARKERS DIVISION <i>John Doe</i>	
69. SIGNATURE OF ARCHIVES DIVISION <i>John Doe</i>		70. SIGNATURE OF LIBRARY DIVISION <i>John Doe</i>	
71. SIGNATURE OF MUSEUM DIVISION <i>John Doe</i>		72. SIGNATURE OF BOTANICAL GARDEN DIVISION <i>John Doe</i>	
73. SIGNATURE OF ZOOLOGICAL GARDEN DIVISION <i>John Doe</i>		74. SIGNATURE OF AQUARIUM DIVISION <i>John Doe</i>	
75. SIGNATURE OF CONSERVATION DIVISION <i>John Doe</i>		76. SIGNATURE OF PARKS AND RECREATION DIVISION <i>John Doe</i>	
77. SIGNATURE OF HISTORIC LANDMARKS DIVISION <i>John Doe</i>		78. SIGNATURE OF MONUMENTS AND MARKERS DIVISION <i>John Doe</i>	
79. SIGNATURE OF ARCHIVES DIVISION <i>John Doe</i>		80. SIGNATURE OF LIBRARY DIVISION <i>John Doe</i>	
81. SIGNATURE OF MUSEUM DIVISION <i>John Doe</i>		82. SIGNATURE OF BOTANICAL GARDEN DIVISION <i>John Doe</i>	
83. SIGNATURE OF ZOOLOGICAL GARDEN DIVISION <i>John Doe</i>		84. SIGNATURE OF AQUARIUM DIVISION <i>John Doe</i>	
85. SIGNATURE OF CONSERVATION DIVISION <i>John Doe</i>		86. SIGNATURE OF PARKS AND RECREATION DIVISION <i>John Doe</i>	
87. SIGNATURE OF HISTORIC LANDMARKS DIVISION <i>John Doe</i>		88. SIGNATURE OF MONUMENTS AND MARKERS DIVISION <i>John Doe</i>	
89. SIGNATURE OF ARCHIVES DIVISION <i>John Doe</i>		90. SIGNATURE OF LIBRARY DIVISION <i>John Doe</i>	
91. SIGNATURE OF MUSEUM DIVISION <i>John Doe</i>		92. SIGNATURE OF BOTANICAL GARDEN DIVISION <i>John Doe</i>	
93. SIGNATURE OF ZOOLOGICAL GARDEN DIVISION <i>John Doe</i>		94. SIGNATURE OF AQUARIUM DIVISION <i>John Doe</i>	
95. SIGNATURE OF CONSERVATION DIVISION <i>John Doe</i>		96. SIGNATURE OF PARKS AND RECREATION DIVISION <i>John Doe</i>	
97. SIGNATURE OF HISTORIC LANDMARKS DIVISION <i>John Doe</i>		98. SIGNATURE OF MONUMENTS AND MARKERS DIVISION <i>John Doe</i>	
99. SIGNATURE OF ARCHIVES DIVISION <i>John Doe</i>		100. SIGNATURE OF LIBRARY DIVISION <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5558 CERTIFICATE OF DEATH

Reg. Dist. No.

05559

1. PLACE OF DEATH a. DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DELEWARE b. COUNTY SUSSEX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE				c. LENGTH OF STAY IN 1b 2 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSP.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLSBORO 46 X-3			
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) DARCEY LEE MILLS				4. DATE OF DEATH MAY 5 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 24, 1958	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 3 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HOWARD MILLS			
14. MOTHER'S MAIDEN NAME BETTY LEE BRAMBLE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NO				17. INFORMANT HOWARD MILLS MILLSBORO DELEWARE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FEW WEEKS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from April 22, 1959 , to May 6, 1959 , that I last saw the deceased alive on May 6, 1959 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lewis M. Burdette M.D.				ADDRESS (Street, city or town, state) 1 Locust St.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Lewis M. Burdette				Cambridge Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 8, 1959		22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEN PARK		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE				ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR DATE MAY 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05560

5559 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Sev. Yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 15 Bethel Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Bethel Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sir Walter Middle Molock Last Molock		4. DATE OF DEATH Month May Day 18 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1872
9. AGE (In years lost birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isaac Molock	
14. MOTHER'S MAIDEN NAME Frances Anne Nichols		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Alonzo Molock, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Cardiac decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic cardiovascular renal disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 59 , to May 18 , 19 59 , that I last saw the deceased alive on 18 May , 19 59 , and that death occurred at 10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 5-21-59 ACTUAL SIGNATURE J. Edwin Fassett M.D. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/1959	
22c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery		22d. LOCATION (City, town, or county) (State) Vienna, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard M. St. Charles ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. H.			

05501

2550 CERTIFICATE OF DEATH

1. NAME OF DECEASED MARY ANN		2. SEX F		3. AGE 65		4. DATE OF BIRTH JAN 15 1885		5. PLACE OF BIRTH BALTIMORE, MD	
6. OCCUPATION HOUSEWIFE		7. MARITAL STATUS MARRIED		8. RACE WHITE		9. RELIGION METHODIST		10. EDUCATION HIGH SCHOOL	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. PERIOD OF ILLNESS 2 WEEKS		14. PLACE OF DEATH HOME		15. TIME OF DEATH 10:30 AM	
16. SIGNATURE OF PHYSICIAN J. H. SMITH		17. SIGNATURE OF WITNESSES J. H. SMITH, M.D. J. H. SMITH, M.D.		18. SIGNATURE OF DECEASED MARY ANN		19. SIGNATURE OF NEXT OF KIN J. H. SMITH		20. SIGNATURE OF REGISTRAR J. H. SMITH	

Handwritten signature: J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05561

5571

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Vienna</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Vienna</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD 1</u>		d. STREET ADDRESS <u>RFD 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Aron</u> Middle <u>Hilton</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Frank Parker</u>		14. MOTHER'S MAIDEN NAME <u>Charlesanna Hollis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-01-9259</u>	
17. INFORMANT <u>Mrs Eva Dixon, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Coronary heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 19 <u>58</u> , to <u>May 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St. Cambridge</u> DATE SIGNED ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/6/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sols Landing Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Soltau</u>		24a. REC'D BY REGISTRAR <u>MAY 26 '59</u>	
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

5572 CERTIFICATE OF DEATH

05562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 50		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Brewster Last Parker		4. DATE OF DEATH Month May Day 23 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1886
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months 1 Days 23 Hours 59 Min.	11. IF UNDER 24 HRS. Months 1 Days 23 Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. James Parker		14. MOTHER'S MAIDEN NAME Mary Elizabeth Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-32-5030	
17. INFORMANT Mrs. Clara D. Parker, Vienna, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 month 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/23/59 19 59 , to 5/23 19 59 , that I last saw the deceased alive on 5/20 19 59 , and that death occurred at 5:45 A M, from the causes and on the date stated above.		DATE SIGNED 5/25/59	
ACTUAL SIGNATURE Lawrence Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Race St Cambridge, Md	
PHYSICIAN'S NAME (Type) Lawrence Maryanov M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 26, 1959	
22c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery		22d. LOCATION (City, town, or county) (State) Vienna, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR MAY 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Davis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5573

CERTIFICATE OF DEATH

05563

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Church Creek</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linas Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>H.</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 12, 1946</u>	
9. AGE (In years last birthday) <u>13</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Charles W. Phillips</u>			
14. MOTHER'S MAIDEN NAME <u>Hazel Mc Namara</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Charles W. Phillips, Linas Road, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>292.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sickle Cell anemia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>under</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY. Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>5/16</u> , 19 <u>59</u> , to <u>5/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>59</u> , and that death occurred at <u>12</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur R. Wynn</u> M.D. <u>136 Race N. E.</u>				DATE SIGNED <u>5/22/59</u>			
PHYSICIAN'S NAME (Type) <u>Cambridge Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/24/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Linas Road</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur R. Wynn</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur R. Wynn</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

05563

<p>1. NAME OF DECEASED <i>John A. Smith</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1955</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CITY OR TOWN <i>Baltimore</i></p>		<p>8. COUNTY <i>Harford</i></p>		<p>9. STATE <i>Maryland</i></p>	
<p>10. OCCUPATION <i>Engineer</i></p>		<p>11. CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>12. MANNER OF DEATH <i>Natural</i></p>	
<p>13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i></p>		<p>14. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>15. SIGNATURE OF WITNESSES <i>Mr. & Mrs. J. A. Smith</i></p>	
<p>16. DATE OF SIGNATURE <i>Jan 15 1955</i></p>		<p>17. TIME OF SIGNATURE <i>11:00 AM</i></p>		<p>18. PLACE OF SIGNATURE <i>Home</i></p>	
<p>19. SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>		<p>20. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>21. SIGNATURE OF WITNESSES <i>Mr. & Mrs. J. A. Smith</i></p>	
<p>22. DATE OF SIGNATURE <i>Jan 15 1955</i></p>		<p>23. TIME OF SIGNATURE <i>11:00 AM</i></p>		<p>24. PLACE OF SIGNATURE <i>Home</i></p>	

John A. Smith

5574

CERTIFICATE OF DEATH

05564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>1MO-18DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JULIUS OTTO REYNOLDS</u>				4. DATE OF DEATH Month Day Year <u>MAY 25 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 11, 1899</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID REYNOLDS</u>				14. MOTHER'S MAIDEN NAME <u>HELEN KNEFELY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY OCCLUSION,</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>CEREBRAL EMBOLISM</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LUPUS ARYTHEMATOSIS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>APRIL 7, 1959</u> to <u>MAY 25, 1959</u> , that I last saw the deceased alive on <u>MAY 25, 1959</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTERN SHORE STATE HOSP. CAMBRIDGE</u> DATE SIGNED <u>5/27/59</u>							
ACTUAL SIGNATURE <u>Harry J. Crawford</u>				PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				24a. REC'D BY REGISTRAR <u>RENNETH R. THOMAS Cambridge Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

03504

CERTIFICATE OF DEATH

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE

DATE

PLACE

OFFICE

STATE

COUNTY

TOWNSHIP

SECTION

RANGE

ZONE

FOR STATE
HEALTH DEPT.

5575

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5 weeks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queen Anne 20X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S. State Hosp.			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles Rhodes			4. DATE OF DEATH Month May Day 18 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/68	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Rhodes			14. MOTHER'S MAIDEN NAME Mary Anne Council		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Records E.S.S. Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck femur 5/4/59					INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell in hospital.			
20c. TIME OF INJURY Month, Day, Year ? Hour o. m. 5-4-59 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
		20f. (City or town) Cambridge		(County) Dor. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace Jr.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) John Mace Jr.			DATE SIGNED 5/18/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF May 21/59		22c. NAME OF CEMETERY OR CREMATORY Hallsboro	
23. FUNERAL DIRECTOR'S SIGNATURE J. V. Moore		ADDRESS Son Denton		24a. REC'D BY REGISTRAR DATE MAY 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Deputy Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 5/55

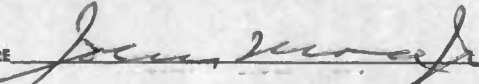
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5576

05566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg - Rural</u>		c. LENGTH OF STAY IN 1b <u>40 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock - Rural</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hurlock Road</u>				d. STREET ADDRESS <u>Near Shiloh</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Evelyn</u> Last <u>Rieley</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1906</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Preston, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Conway</u>				14. MOTHER'S MAIDEN NAME <u>Lettie Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Norman Conway, Hurlock, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial injury</u> <u>812x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Fracture base of skull.</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian hit by auto.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12:30 AM 5/17/59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Williamsburg Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thompsonstown Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Near East New Market, Md.</u>				22e. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

09

2

5577

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write BISHOPS HEAD) c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL (If not in hospital, give street address) RURAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOPS HEAD d. STREET ADDRESS RURAL e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First ARNIE Middle P Last ROBINSON		4. DATE OF DEATH Month MAY Day 19 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1884
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General store	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SLEIGHTER ROBERSON		14. MOTHER'S MAIDEN NAME HESTER JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT FLORENCE WOODLAND		Address BISHOPS HEAD MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, massive DUE TO Cerebral sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arterio-sclerosis DUE TO General Arterio-sclerosis (c) General Arterio-sclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decomposition			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1959 , to May 1959 , that I last saw the deceased alive on May 19 , 1959, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge Md DATE SIGNED Cambridge Md			
ACTUAL SIGNATURE J V THOMPSON PHYSICIAN'S NAME (Type) J V THOMPSON M D		M.D. Cambridge Md CAMBRIDGE MARYLAND	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	22b. DATE THEREOF MAY 22 1959	22c. NAME OF CEMETERY OR CREMATORY MURPHY CEMETERY	22d. LOCATION (City, town, or county) (State) BISHOPS HEAD MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FUNERAL SERVICE		ADDRESS CAMBRIDGE MARYLAND	24a. REC'D BY REGISTRAR MAY 22 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES W. WILSON		JAN 23, 1934		BALTIMORE, MD.	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JAN 15, 1869		BALTIMORE, MD.		JAN 15, 1892	
FATHER'S NAME		MOTHER'S NAME		EDUCATION	
JAMES W. WILSON		MARY A. WILSON		HIGH SCHOOL	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Carpenter		Heart Disease		Natural	
RESIDENCE		DATE OF INTERMENT		PLACE OF INTERMENT	
1234 N. E. ST.		JAN 25, 1934		CATHOLIC CHURCH	
CITY		COUNTY		STATE	
BALTIMORE		BALTIMORE		MD.	
DECEASED'S SIGNATURE		WITNESSES' SIGNATURES		REGISTRAR'S SIGNATURE	
JAMES W. WILSON		J. W. WILSON, M.D.		J. W. WILSON, M.D.	
DATE		TIME		PLACE	
JAN 23, 1934		10:30 AM		CATHOLIC CHURCH	

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

5578 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>6 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>P.</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 14, 1877</u>	
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John W. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-20-4807</u>			
17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Endocarditis</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Generalized Arteriosclerosis with hypertension</u> Sev. yrs. (c) <u>Senile Psychosis</u> -- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 8, 1958</u> to <u>May 7, 1959</u> , that I lost sowing the deceased alive on <u>May 7, 1959</u> , and that death occurred at <u>10:00 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Simon Virkutis</u> M.D. <u>E.S.S. H.</u> <u>5-7-59</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Simon Virkutis</u> <u>Eastern Shore State Hospital, Cambridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>				22b. DATE THEREOF <u>5/14/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mill Pond Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Mill Pond Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellon Millington Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

05208

DEPARTMENT OF HEALTH

1957

100

1

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5579

CERTIFICATE OF DEATH

Reg. Dist. No.

05569

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 3				c. LENGTH OF STAY IN TB 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Pike Last Schaffner				4. DATE OF DEATH Month May Day 14 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1891	
9. AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Lynn, Mass.		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Leander D. Ellis				14. MOTHER'S MAIDEN NAME Georgia Gale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				17. INFORMANT Address Frank L. Schaffner, Cambridge, Md. R.D. 3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung (metastatic) 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of kidney DUE TO (c) Emaciation				INTERVAL BETWEEN ONSET AND DEATH 4 mos. 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emaciation				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from May 13, 1959 , to May 14, 1959 , that I last saw the deceased alive on May 13, 1959 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James W. Thompson M.D. Cambridge, Md.				DATE SIGNED May 14, 1959			
PHYSICIAN'S NAME (Type) James W. Thompson				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF May 16, 1959				22c. NAME OF CEMETERY OR CREMATORY Ridgewood Cemetery		22d. LOCATION (City, town, or county) (State) North Andover, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth X. Showers ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR DATE MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5580

Item 7 Film G243 5/28/59 cap

CERTIFICATE OF DEATH

05570

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY DORCHESTER MIDDLE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write nearest town) HUDSON				c. LENGTH OF STAY IN b. LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDITH First Middle MARSHALL last SEWARD				4. DATE OF DEATH Month MAY Day 23 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2 1872	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES MARSHALL				14. MOTHER'S MAIDEN NAME JOSEPHIN E CARDWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 07 7751		17. INFORMANT Address LESLIE SEWARD H UDSON MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHR. NEPHRITIS DUE TO (c) HYPERTENSION - ESSENTIAL						INTERVAL BETWEEN ONSET AND DEATH 1 day 2 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MAL NUTRITION						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 5/10 , 19 40 , to 5/23 , 19 59 , that I last saw the deceased alive on 5/23 , 19 59 , and that death occurred at 7 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks MD			ADDRESS (Street, city or town, state) 104 Locust St CAMBRIDGE MARYLAND		DATE SIGNED 5/25/59		
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF MAY 26, 1959	22c. NAME OF CEMETERY OR CREMATORY SPEDDENS SEWARD CEMETERY HUDSON MARYLAND		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNERAL SERVICE CAMBRIDGE MARYLAND			24a. REC'D BY REGISTRAR DATE MAY 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5560 CERTIFICATE OF DEATH

05571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home				d. STREET ADDRESS 116 Locust St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgar Beckwith Simmons				4. DATE OF DEATH Month May Day 19 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1870		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Insurance agent			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Josias S. Simmons				14. MOTHER'S MAIDEN NAME Leah Beckwith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Howard W. Simmons, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic CVD DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 wk yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17, 1953 to 5-19, 1959 , that I last saw the deceased alive on 5-19, 1959 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Bannerman M.D.				ADDRESS (Street, City or town, state) Cambridge, Md. DATE SIGNED 5-19-59			
PHYSICIAN'S NAME (Type) W. Bannerman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 21, 1959		22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE MAY 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5561 CERTIFICATE OF DEATH

05572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Rochester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reids Grove</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Methodist Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>May</u> Last <u>Sisselberger</u>		4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/1889</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Sisselberger</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Kiechert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>100-111111-1111</u>	
17. INFORMANT <u>Mod Vicky Bell</u>		Address <u>Reids Grove Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR RENAL DISEASE</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/18</u> , 19 <u>59</u> , to <u>5/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Gunby</u> M.D.		ADDRESS (Street, city or town, state) <u>105 CHURCH ST.</u> DATE SIGNED <u>5/25/59</u>	
PHYSICIAN'S NAME (Type) <u>WALTER E. GUNBY JR.</u>		<u>CAMBRIDGE</u> <u>M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Keith S. Hillyough</u>		ADDRESS <u>East New Market</u>	
24a. REC'D BY REGISTRAR <u>May 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME [Faint text, illegible]		SEX [Faint text, illegible]	
AGE [Faint text, illegible]		DATE OF BIRTH [Faint text, illegible]	
PLACE OF BIRTH [Faint text, illegible]		RACE [Faint text, illegible]	
OCCUPATION [Faint text, illegible]		CAUSE OF DEATH [Faint text, illegible]	
PLACE OF DEATH [Faint text, illegible]		DATE OF DEATH [Faint text, illegible]	
TIME OF DEATH [Faint text, illegible]		SIGNATURE OF DECEASED [Faint text, illegible]	
SIGNATURE OF WITNESS [Faint text, illegible]		SIGNATURE OF PHYSICIAN [Faint text, illegible]	
SIGNATURE OF CLERK [Faint text, illegible]		SIGNATURE OF REGISTRAR [Faint text, illegible]	



This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the office of the Registrar of the County or City in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5581 CERTIFICATE OF DEATH

Reg. Dist. No.

05573

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Q.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 6 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELMER Middle Last SMITH		4. DATE OF DEATH Month May Day 20 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/02
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dave Smith		14. MOTHER'S MAIDEN NAME Wilhelmina Lane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Eastern Shore State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Chronic myocardial degeneration DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 26, 1958 to May 20, 1959 , that I last saw the deceased alive on May 20, 1959 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Dredge M.D.		ADDRESS (Street, city or town, state) Cambridge Md DATE SIGNED 5-20-59	
PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/59	
22c. NAME OF CEMETERY OR CREMATORY St. Catherine		22d. LOCATION (City, town, or county) (State) St. Catherine Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		24a. REC'D BY REGISTRAR Arthur S. Kline	
ADDRESS Edgar L. Lane		DATE MAY 25 '59	

85573

1951 CERTIFICATE OF LEADIN

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5562 CERTIFICATE OF DEATH

05574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorch.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 65 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alfred Middle Jerry Last Stack		4. DATE OF DEATH Month May Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1874
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hurlock, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Stack		14. MOTHER'S MAIDEN NAME Sarah Nichols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs. Helen Borge, Glasgow St., Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, massive 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and cerebral DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 38 hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- 19 p. m. --		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-25-59 , 19__, to 5-26-59 , 19__, that I last saw the deceased alive on 5-26-59 , 19__, and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldridge H. Wolff		ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 5-27-59	
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth P. Thomas ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06722

5563 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6 1/2 Pine Street</u>		d. STREET ADDRESS <u>6 1/2 Pine Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Washington</u> Last <u>Stanley</u>		4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentering</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Demby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-32-9351</u>	
17. INFORMANT <u>Flossie Stanley, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, recurrent</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral sclerosis</u> DUE TO (c) <u>Arterio-sclerosis, gen.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac failure, Hypertension, etc.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 30</u> , 19 <u>59</u> , to <u>May 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>59</u> , and that death occurred at <u>7:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>June 2, 59</u>			
ACTUAL SIGNATURE <u>James H. Thompson</u> M.D.		PHYSICIAN'S NAME (Type) <u>James H. Thompson</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Thompson</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10383

Reg. Dist. No.

1. Name of deceased (Print name in full) <i>John Doe</i>		2. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of birth <i>Jan 1, 1900</i>		4. Place of birth <i>City, State</i>	
5. Date of death <i>Dec 1, 1950</i>		6. Place of death <i>City, State</i>	
7. Cause of death (List all causes) <i>Heart disease</i>		8. Manner of death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined	
9. Signature of physician <i>Dr. John Doe</i>		10. Signature of registrar <i>John Doe</i>	
11. Signature of informant <i>John Doe</i>		12. Signature of witness <i>John Doe</i>	
13. Signature of funeral director <i>John Doe</i>		14. Signature of undertaker <i>John Doe</i>	
15. Signature of cemetery <i>John Doe</i>		16. Signature of burial place <i>John Doe</i>	
17. Signature of burial place <i>John Doe</i>		18. Signature of burial place <i>John Doe</i>	
19. Signature of burial place <i>John Doe</i>		20. Signature of burial place <i>John Doe</i>	
21. Signature of burial place <i>John Doe</i>		22. Signature of burial place <i>John Doe</i>	
23. Signature of burial place <i>John Doe</i>		24. Signature of burial place <i>John Doe</i>	
25. Signature of burial place <i>John Doe</i>		26. Signature of burial place <i>John Doe</i>	
27. Signature of burial place <i>John Doe</i>		28. Signature of burial place <i>John Doe</i>	
29. Signature of burial place <i>John Doe</i>		30. Signature of burial place <i>John Doe</i>	
31. Signature of burial place <i>John Doe</i>		32. Signature of burial place <i>John Doe</i>	
33. Signature of burial place <i>John Doe</i>		34. Signature of burial place <i>John Doe</i>	
35. Signature of burial place <i>John Doe</i>		36. Signature of burial place <i>John Doe</i>	
37. Signature of burial place <i>John Doe</i>		38. Signature of burial place <i>John Doe</i>	
39. Signature of burial place <i>John Doe</i>		40. Signature of burial place <i>John Doe</i>	
41. Signature of burial place <i>John Doe</i>		42. Signature of burial place <i>John Doe</i>	
43. Signature of burial place <i>John Doe</i>		44. Signature of burial place <i>John Doe</i>	
45. Signature of burial place <i>John Doe</i>		46. Signature of burial place <i>John Doe</i>	
47. Signature of burial place <i>John Doe</i>		48. Signature of burial place <i>John Doe</i>	
49. Signature of burial place <i>John Doe</i>		50. Signature of burial place <i>John Doe</i>	
51. Signature of burial place <i>John Doe</i>		52. Signature of burial place <i>John Doe</i>	
53. Signature of burial place <i>John Doe</i>		54. Signature of burial place <i>John Doe</i>	
55. Signature of burial place <i>John Doe</i>		56. Signature of burial place <i>John Doe</i>	
57. Signature of burial place <i>John Doe</i>		58. Signature of burial place <i>John Doe</i>	
59. Signature of burial place <i>John Doe</i>		60. Signature of burial place <i>John Doe</i>	
61. Signature of burial place <i>John Doe</i>		62. Signature of burial place <i>John Doe</i>	
63. Signature of burial place <i>John Doe</i>		64. Signature of burial place <i>John Doe</i>	
65. Signature of burial place <i>John Doe</i>		66. Signature of burial place <i>John Doe</i>	
67. Signature of burial place <i>John Doe</i>		68. Signature of burial place <i>John Doe</i>	
69. Signature of burial place <i>John Doe</i>		70. Signature of burial place <i>John Doe</i>	
71. Signature of burial place <i>John Doe</i>		72. Signature of burial place <i>John Doe</i>	
73. Signature of burial place <i>John Doe</i>		74. Signature of burial place <i>John Doe</i>	
75. Signature of burial place <i>John Doe</i>		76. Signature of burial place <i>John Doe</i>	
77. Signature of burial place <i>John Doe</i>		78. Signature of burial place <i>John Doe</i>	
79. Signature of burial place <i>John Doe</i>		80. Signature of burial place <i>John Doe</i>	
81. Signature of burial place <i>John Doe</i>		82. Signature of burial place <i>John Doe</i>	
83. Signature of burial place <i>John Doe</i>		84. Signature of burial place <i>John Doe</i>	
85. Signature of burial place <i>John Doe</i>		86. Signature of burial place <i>John Doe</i>	
87. Signature of burial place <i>John Doe</i>		88. Signature of burial place <i>John Doe</i>	
89. Signature of burial place <i>John Doe</i>		90. Signature of burial place <i>John Doe</i>	
91. Signature of burial place <i>John Doe</i>		92. Signature of burial place <i>John Doe</i>	
93. Signature of burial place <i>John Doe</i>		94. Signature of burial place <i>John Doe</i>	
95. Signature of burial place <i>John Doe</i>		96. Signature of burial place <i>John Doe</i>	
97. Signature of burial place <i>John Doe</i>		98. Signature of burial place <i>John Doe</i>	
99. Signature of burial place <i>John Doe</i>		100. Signature of burial place <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5582 CERTIFICATE OF DEATH

05575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>22-12-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>527 W. College Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>-</u> Last <u>Stewart</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 2, 1880</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u>	
IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk - Former</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Employee (Bread Co.)</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland (Shad Point)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>214-10-9414A</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>--</u> <u>--</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 28, 1958</u> , to <u>May 20, 1959</u> , that I last saw the deceased alive on <u>May 20, 1959</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. De Filippis</u>		ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital, Cambridge, Md.</u> DATE SIGNED <u>5-21-59</u>	
PHYSICIAN'S NAME (Type) <u>E. DeFilippis</u>		Eastern Shore State Hospital, Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 23, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shad Point Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.D./Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

02533

2582

1